



**OFFICE OF PUBLIC INSTRUCTION**

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**Linda McCulloch**  
Superintendent

**Supplemental Educational Services  
Provider Selection Form**

**Student Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_

**Cell Phone #:** \_\_\_\_\_

**Parent(s)/Guardian(s):** \_\_\_\_\_

**School:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

Check the box that applies:

☐ My son/daughter **WILL** participate in the Supplemental Educational Services program.

☐ I am selecting the following state-approved provider from the approved list provided to me.

\_\_\_\_\_  
(Supplemental Educational Services Provider)

☐ I understand that the district will enter into an agreement with the provider, and I will be notified of a time to meet with the provider to set goals for my child.

☐ I understand that the provider will regularly inform me and the student's teacher(s) of my child's progress.

☐ I understand that if funds are insufficient to cover the supplemental educational services for all of the students who choose to participate, participation will be based on prioritized academic need as defined by the district.

\_\_\_\_\_  
**Signature of parent/guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of parent/guardian**

\_\_\_\_\_  
**Date**

*"It is the mission of the Office of Public Instruction to improve teaching and learning through communication, collaboration, advocacy, and accountability to those we serve."*